**AUTHORIZATION FOR THE DISCLOSURE OF INFORMATION TO FACILITY BY ANOTHER ENTITY**

*The information found in this document is for informational purposes only. The information provided is not to be used or construed as legal interpretation.*

At the request of General Hospital ("Facility"), Patient hereby authorizes [**name of other covered entity maintaining the protected health information**] to disclose [**specific description of the information to be disclosed**] ("protected health information") to Facility for the following purpose(s): [**description of each purpose of the requested disclosure**].

Patient hereby acknowledges that he/she understands that treatment, payment, enrollment in the health plan, or eligibility for benefits is not conditioned on his/her signing of this Authorization. However, Facility may condition the provision of health care that is solely for the purpose of creating protected health information on Patient's signing of this Authorization, and Facility may condition the provision of research-related treatment on Patient's signing of this Authorization for the use and disclosure of protected health information created for research that includes treatment of the individual.

Patient may refuse to sign this Authorization if he/she so chooses.

The Facility may use or disclose such protected health information only until [**expiration date** or **expiration event relating to the individual or purpose of the use or disclosure**].

At all times, Patient retains the right to revoke this Authorization, except if the Authorization was obtained as a condition of obtaining insurance coverage. Such revocation must be submitted to the Facility in writing. The revocation shall be effective *except* to the extent that the Facility has already used or disclosed information in reliance on the Authorization. Patient may revoke this Authorization by [**describe how Patient may revoke; e.g., where to send a written notice**].

Patient has been informed and understands that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient of such information, and, at that point, the information may no longer be protected under the terms of this agreement.

**I HAVE READ AND UNDERSTAND THIS INFORMATION. I HAVE RECEIVED A COPY OF THIS FORM AND I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS SEALED [SEALED SIGNATURES ARE OPTIONAL] DOCUMENT VERIFYING AUTHORIZATION FOR THE USE OR DISCLOSURE THE PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS**

Date:_____ Time _____AM/PM

_____(SEAL)
Signature of Patient

_____
Please print name

_____(SEAL)
Signature of witness

_____(SEAL)
Person Signing on behalf of Patient*

_____
Please print name

_____
Please print name

*Please explain Representative's Relationship to Patient and include a description of Representative's Authority to act on behalf of Patient:

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